Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X*		(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB	JMBER: A. BUILD		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
NVS315AGC		NVS315AGC		B. WING		05/1	9/2009	
NAME OF PROVIDER OR SUPPLIER NEW HORIZON REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 700 ALHAMBRA DR. LAS VEGAS, NV 89104					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
Y 000	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 5/19/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with chronic illnesses and/or persons with mental illness, Category II Residents. The census at the time of the survey was eight. Eight resident files were reviewed and two employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of C.			Y 000				
	The following deficien	ncies were identified:						
Y 103 SS=C	449.200(1)(d) Persor	nnel File - NAC 441A		Y 103				
	a separate personne member of the staff of (d) The health certific chapter 441A of NAC		ach Iude: to					
	This Regulation is not met as evidenced by:							

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

		(X1) PROVIDER/SUPPLIER/0 IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
NVS315AGC				B. WING		05/19/2009			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	-			
NEW HORIZON REST HOME				ALHAMBRA DR. VEGAS, NV 89104					
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Y 103	Continued From page	2 1		Y 103					
	Based on record review on 5/19/09, the facility failed to ensure 1 of 2 caregivers complied with NAC 441A.375 regarding a new employee physical (Employee #2).								
	Severity: 1 Scope: 3								
Y 175 SS=F	1 101 2 0 (1)(0) 1 10 0 11 11 11 11 11 11 11 11 11 11 11		the ethe de	Y 175					
	· ·								
Y 178 SS=C	449.209(5) Health an	d Sanitation-Maintain Iı	nt/Ext	Y 178					
	ensure that the premi	of a residential facility s ses are clean and that andscaping of the facili	the						

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB	BER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
	NVS315AGC			B. WING		05/19/2009	
NEW HODIZON BEST HOME 700 ALH			STREET ADDR 700 ALHAM LAS VEGAS	DDRESS, CITY, STATE, ZIP CODE AMBRA DR.			
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Y 178	This Regulation is not met as evidenced by: Based on observation on 5/19/09, the facility failed to ensure the bathrooms were free from mold. There was a large amount of mold in the shower in the bathroom connecting Bedroom #3. This was a repeat deficiency from the 7/24/08 State Licensure survey.		Y 178				
Y 254 SS=F	Severity: 1 Scope: 3 449.217(5) Storage of Food-No chemicals, detergents			Y 254			
	NAC 449.217 5. Pesticides and other toxic substances must not be stored in any area in which food, kitchen equipment, utensils or paper products are stored. Soaps, detergents, cleaning compounds and similar substances must not be stored in any area in which food is stored.						
	Based on observation	ot met as evidenced by n on 5/19/09 the facility ubstances were not stor	failed				
	Severity: 2 Scop	e: 3					
Y 693 SS=F	449.2712(2) Oxygenability	-Caregiver monitor resid	dent	Y 693			

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS315AGC 05/19/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 700 ALHAMBRA DR. **NEW HORIZON REST HOME** LAS VEGAS, NV 89104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 693 Continued From page 3 Y 693 NAC 449.2712 2. The caregivers employed by a residential facility with a resident who requires the use of (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician. (b) Ensure That: (1) The resident's physician evaluates periodically the condition of the resident which necessitates his use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks. (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident.

PRINTED: 05/20/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS315AGC 05/19/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 700 ALHAMBRA DR. **NEW HORIZON REST HOME** LAS VEGAS. NV 89104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 693 Continued From page 4 Y 693 This Regulation is not met as evidenced by: Based on observation on 5/19/09 the facility failed to secure 15 oxygen tanks in a rack or to the wall in the outside storage shed. Severity: 2 Scope: 3 Y 882 Y 882 449.2742(6)(c) Medication / change order SS=D NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744.

This Regulation is not met as evidenced by: Based on record review on 5/19/09 the facility failed to ensure medication labels matched physician orders for 1 of 8 residents (Residents

#2).

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